UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

BRAND NAME MEDICATION
ANTI-EPILEPTIC AGENTS

Patient name:_____Medicaid ID #:_____

Prescriber Name:_____Prescriber NPI#:_____ Contact person:_____

Prescriber Phone#:_____Extension/Option:_____ Fax#:_____

Pharmacy:_____Pharmacy Phone#:_____Pharmacy Fax #:_____

Requested Medication:_____Strength:_____Frequency/Day:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES TO (801) 536-0477

CRITERIA:

- **NOTE:** This Prior Authorization is only valid for patients being treated for seizure disorders. No other diagnoses will be considered.
- **NOTE:** Only patients stable on brand-name anti-epileptic agents will be permitted to continue use, with the completion and approval of this form.
- Documented diagnosis of seizure disorder
- Detailed notes indicating why treatment was initiated with the branded product

OR

- Details of adverse reaction, allergy or inadequate response to the generic equivalent

NOTES: This Prior Authorization is only available to clients enrolled in Traditional Medicaid (Purple Card). Clients enrolled in Non-Traditional Medicaid (Blue Card) or Primary Care Network (Yellow Card) must pay full price for brand name medications with available generics.

AUTHORIZATION:
One year

RE-AUTHORIZATION:
Telephone request from physician's office or pharmacy